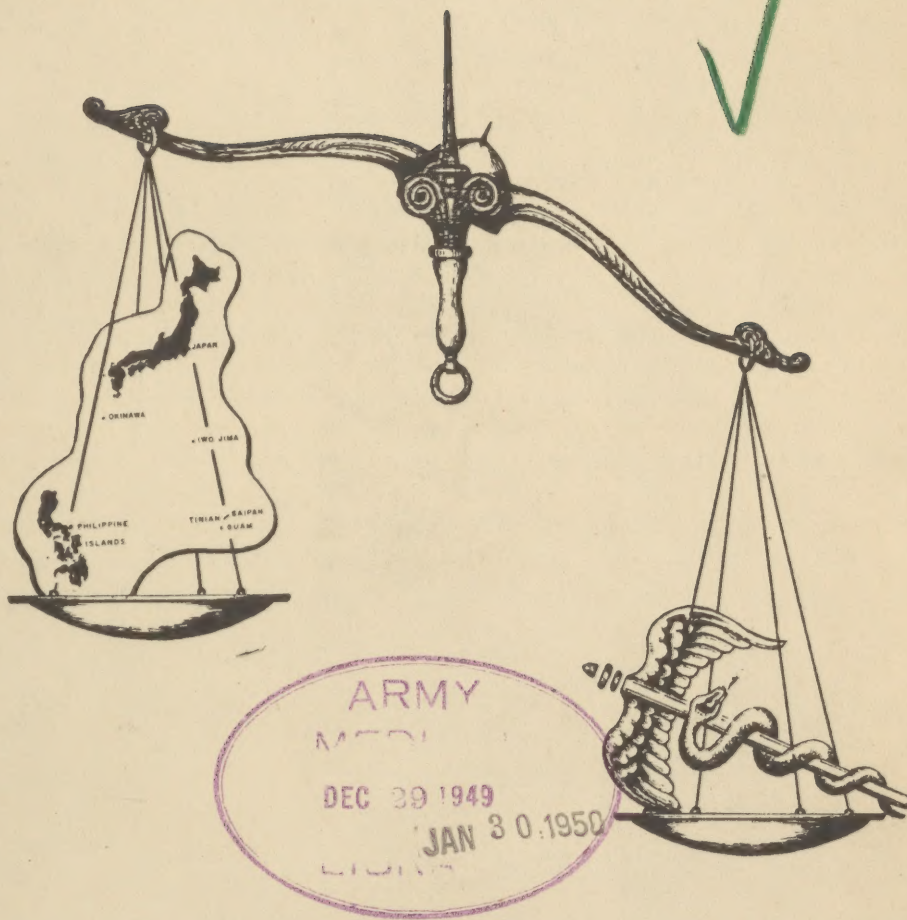


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MED SEC GHQ FEC

VOL IV NO 12
1 DEC 1949



A FAR EAST PERIODICAL OF MEDICAL DEPARTMENT INFORMATION

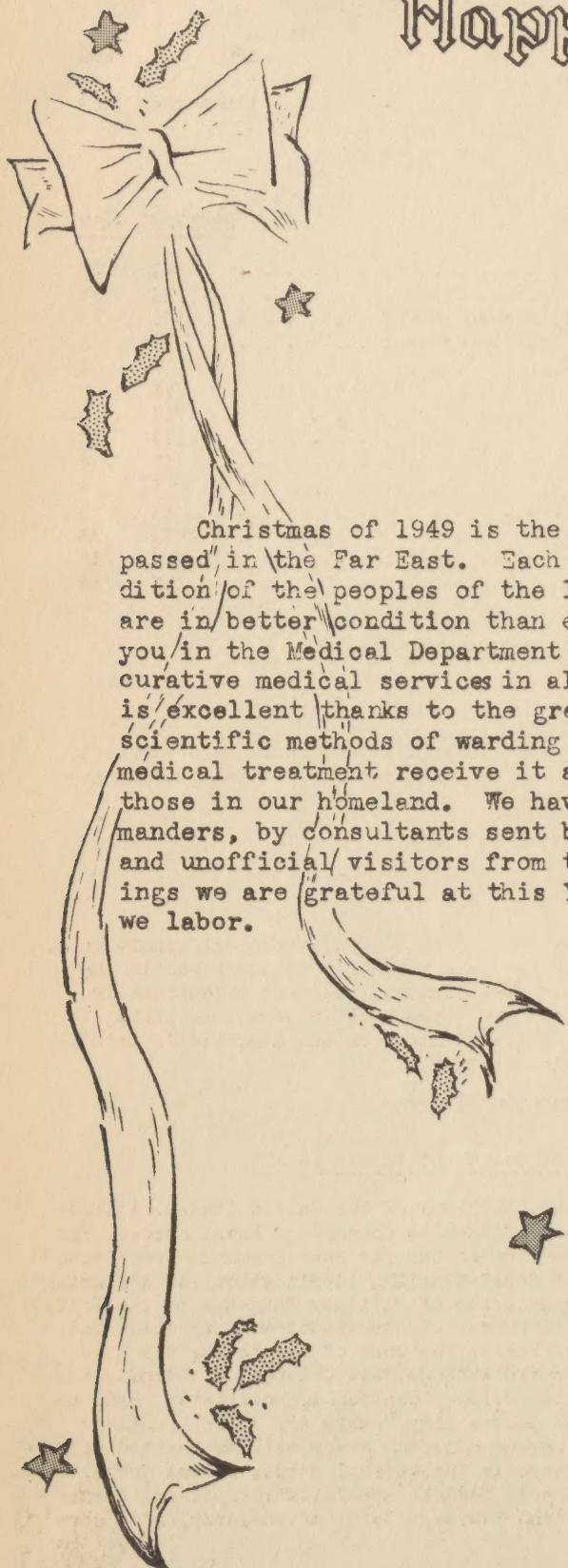
SURGEON'S CIRCULAR LETTER

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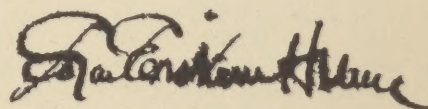
Merry Christmas

Happy New Year

25 December 1949



Christmas of 1949 is the fifth that American occupation personnel have passed in the Far East. Each year has witnessed improvements in the condition of the peoples of the lands in which we serve. The Armed Forces are in better condition than ever. With a minimum of personnel and cost, you in the Medical Department have maintained superior preventive and curative medical services in all their aspects. The health of our service is excellent thanks to the great degree with which you have applied modern scientific methods of warding off disease and injury. Persons who require medical treatment receive it at institutions which compare favorably with those in our homeland. We have been accorded praise by our military commanders, by consultants sent by The Surgeon General, and by other official and unofficial visitors from the United States. For these and other blessings we are grateful at this Yuletide to the Great Physician in whose service we labor.



EDGAR ERSKINE HUME
Major General
Chief Surgeon

RESTRICTED

GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APC 500

NO.12

1 December 1949

PART I

ADMINISTRATIVE

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I. Organization of the Medical Section

Departure from the Medical Section, General Headquarters, Far East Command: Major James L. LaCombe, MSC, Executive Officer, completed his overseas tour of duty and returned to the zone of interior for reassignment.

II. The Clinico-Pathologic Conference

One of the best and most instructive forms of teaching is the clinico-pathologic conference. When utilized in the manner of the CPC's of the Massachusetts General Hospital, as published in the New England Journal of Medicine, especially when the audience participates, they are exceptionally effective. The 406th Medical General Laboratory, APC 500, now can furnish CPC's on a loan basis to outlying groups, together with slides and photographs of x-rays and the gross and microscopic pathology. Hospital education committees are urged to utilize this material.

III. Chapter of the Association of Military Surgeons of the U. S. Formed in FEC



Members of the Association of Military Surgeons of the United States, including the Chief Surgeon, FEC; Senior Medical Officer to Commander, Naval Forces, Far East, and Surgeon, Far East Air Force, serving in the Far East Command have formed a chapter of the Association known as THE JAPAN CHAPTER. Application for a charter was submitted to the Secretary of the Association of Military Surgeons of the United States, Washington, and has received the approval of the annual meeting which has just ended. Pending final election of officers, the work of completing the provisional chapter organization will go forward with Colonel Chauncey E. Dovell, MC, Surgeon, Eighth Army, as President, and Lt. Colonel Charles A. McAllister, MSC, as

Secretary. Officers of the Medical Department of the United States Army, Navy, Air Force, Public Health Service and Veterans Administration stationed in Japan and adjacent areas will be invited to enter into the organization. Such officers would include those in the Medical Corps, Dental Corps, Veterinary Corps, Nurse Corps, Medical Service Corps and Women's Medical Specialist Corps, and former members of the Sanitary Corps, Medical Administrative Corps and Pharmacy Corps of the Army, also cor-

responding officers of the other federal services, past and present. It is believed that the organization of this chapter will establish a closer liaison between the Services and provide a medium for greater cooperation in the accomplishment of the medical mission in the Far East.

The Association of Military Surgeons is the oldest and largest medical military organization in the world. It is also the oldest of the Service associations in our Armed Forces. Its annual meetings afford a place for not only our own medical officers, but those from other countries to meet and discuss common problems. Under the law the trustees are the Secretaries of the Army, the Navy and the Treasury (under whom the Public Health Service formerly functioned). It is expected that a change in the charter will include the Secretary of the Air Force. The presidency of the Association is held by an officer of each of the component services in turn. The present head is Rear Admiral Joel T. Boone, USN, who succeeded Major General Edgar Erskine Hume, USA, in that office. The 1949 meeting was held in Washington, November 10-12, and was one of the most successful in the Association's long history, with officers from all parts of the United States and delegates from 25 foreign countries.

Unification of Services is no new thing to this Association which, from its very beginning, has brought together medical and other officers of the eligible Services into one composite whole working for the common good. The Cross of membership which was authorized by Act of Congress may be worn upon the uniform of any of the armed services. The honorary membership has been conferred from time to time on senior medical officers of other countries.

The following is a list of the charter members of the chapter which will be administered in accordance with the Constitution and bylaws of the Association:

Major General Edgar Erskine Hume, USA, Chief Surgeon, FEC

Brigadier General Crawford F. Sams, MC, USA, Chief, Public Health & Welfare Section, SCAP

Colonel Robert J. Platt, MC, USAF, Surgeon, Far East Air Forces

Colonel Chauncey E. Dovell, MC, USA, Surgeon, Eighth Army

Captain James B. Butler, MC, USN, Senior Medical Officer to Commander, Naval Forces, Far East

Colonel Frederick R. Wunderlich, DC, USA, Dental Surgeon, Eighth Army, and Executive Officer to Surgeon, Eighth Army

Colonel Irby R. Pollard, VC, USA, Veterinary Consultant, FEC

Lt. Colonel Charles A. McAllister, MSC, USA, Chief, Operations Branch, Medical Section, Eighth Army

Major Mildred I. Clark, ANC, USA, Chief Nurse, Medical Section, FEC

Major Nell Wickliffe, WMSC, USA, Dietetic Consultant, FEC, and Chief Dietitian, Eighth Army

IV. Additions to MOS's and Titles Thereof Pertaining to the Medical Department



The following MOS's have been authorized by C-3, TM 12-406 and are published herein as additions to those listed in "MOS's AND TITLES THEREOF PERTAINING TO THE MEDICAL DEPARTMENT, (Ref TM 12-406 and TM 12-425 A)" inside front cover, Surgeon's Circular Letter, No. 11, 1 November 1949:

3004 Radiological Defense Medical Officer (MC)
 3161 Air Force Staff Surgeon (MC)
 3162 Flight Surgeon (MC)
 3177 Oral Pathologist (DC)
 3308 Medical Radiological Laboratory Officer (MSC)

V. The Doctor, the Medical Supply Officer and Therapeutic Needs

The Medical Supply officer is considered a member of the team that cares for the sick. Ideally

the relationship between the physician who prescribes the treatment for the patient and the supply officer should be one of close cooperation, with each knowing something of the problems that face the other. Medical officers would do well to visit the store rooms and study the supply catalog with a view of anticipating tomorrow's needs. The medical supply catalog lists a great wealth of up-to-date therapeutic agents.

Newer drugs are constantly being added to the Catalog. Non-standard items can also be obtained by proper requisitioning procedures. If requisitioned in time, practically every therapeutic agent in the Catalog can be made available to even the smallest hospital and to the physician in the dispensary.

Look for the drug that is needed under its proper title rather than its trade name. Ceditanid, for instance is carried as Lanatoside C. Careful perusal of the supply catalog and visits and conferences between the supply officer and the physician will pay dividends in having the right item available when and where it is needed.

VI. Residency Training



The following is an extract from a Department of the Army letter received by a Medical Corps officer relative to his application for residency training. It is believed that the information contained therein will be of interest to all Medical Corps officers who have applied for similar training while on duty in the Far East Command.

"1. Your application for residency training in Pathology. . . .has been received in this office.

"2. It is being held for consideration with all the others at the time the Professional Education Committee meets in November of this year. However, I regret that it is not likely that you will be selected at this time. As a Regular Army officer your normal tour of foreign service in the Far East will be for a period of about thirty months, which would make you available in time to start residency training 1 July 1952. Regular Army officers returning from foreign service within a year are always given the first priority when selections for the military residency program are made. Therefore you may be reasonably certain that the Professional Education Committee will select you for a residency in Pathology at an Army hospital beginning on 1 July 1952.

"3. The completion of a normal tour of foreign service before entering on your residency training will definitely work to your advantage because then there will be no interruption to your training.

"4. It is hoped, therefore, that you will decide to remain in the Medical Corps of the Army where there is a great opportunity for a career in the specialty of Pathology."

VII. Courses on Atomic Medicine Slated

Short courses in the fundamental principles of the medical aspects of atomic explosion are open to medical and dental officers of the National Guard and the Organized Reserve Corps.

The course is sponsored by the Armed Forces Special Weapons Project and will be given at the Research and Graduate School, Army Medical Center, Washington, D.C. Four classes are scheduled for the current fiscal year with the first two being held 19 September and 28 November. The next two are scheduled for 6 February and 8 May. Instruction will cover a period of five days.

VIII. Medical Consultants Meet

The Advisory Council, Society of U. S. Medical Consultants in World War II met recently with Maj. Gen. R. W. Bliss, the Surgeon General of the Army, and members of his staff. Among the various papers presented were General Bliss's "Recent Developments Affecting the Medical Department" and a report by Colonel Warner F. Bowers, MC, former Surgical Consultant, FEC, on his recent trips to

overseas commands and the "Recent Developments in the Oversea Consultants Program."

IX. Change of Date in Medical Service Corps Officers' Rank



In accordance with the provisions of Public Law 173, 81st Congress authorizing the adjustment of Medical Service Corps officers, in grade, on the MSC promotion list in the order of their precedence as determined by total amount of service for promotion purposes, the dates or rank, in permanent grade, of the following-named MSC officers are changed to reflect their proper seniority for all purposes in accordance with their precedence on the promotion list.

NAME	PERM GRADE	NEW DATE OF RANK	NAME	PERM GRADE	NEW DATE OF RANK
RIORDAN, Bernard N.	Lt Col	10 Jan 46	SMITH, Marlo E.	Capt	1 Jun 45
CRUSE, Charles F.	Lt Col	28 Oct 47	WILKINS, Arthur L.	Capt	11 Aug 46
MORGAN, James S.	Lt Col	25 Nov 47	WAGNON, Glen B.	Capt	10 Oct 46
BLASINGAME, Floyd J.	Major	21 Oct 41	WARE, Marvin A.	Capt	24 Mar 47
MC KNIGHT, Joe E.	Major	23 Apr 42	MILLESTEIN, Conan H.	Capt	5 Jun 47
DAY, Frank R.	Major	14 Jan 43	MUSCHEL, Louis H.	Capt	4 Jul 47
ORANGE, Arthur J.	Major	31 Jan 43	MALONE, Everett W.	Capt	29 Jul 47
FREEMAN, Monroe E.	Major	1 Apr 43	LOVE, Jack P.	Capt	2 Aug 47
WALKOWSKI, Joseph A.	Major	1 Sep 43	MURPHY, Paul W.	Capt	7 Aug 47
PENNEPACKER, Russell O.	Major	1 Apr 44	FRANCIS, James R.	Capt	23 Aug 47
FETTERMAN, Leland L.	Major	17 May 46	GOOD, Otto S.	Capt	22 Sep 47
VANDEL, Frederick M.	Major	12 Jul 46	WRIGHT, Bertram S.	Capt	23 Sep 47
STARKS, Leslie E.	Major	11 Aug 46	LOISEL, Vernon H.	Capt	24 Sep 47
LONG, James G.	Major	3 Mar 47	KRAUSE, William O.	Capt	18 Oct 47
STEPczyk, Frank	Major	19 Aug 47	HUTCHINSON, Melville C.	Capt	20 Oct 47
NELSON, Harry J.	Major	19 Aug 47	TRAUB, Robert	Capt	26 Oct 47
QUINN, Edward F., Jr.	Major	19 Aug 47	SCHLECHER, Norman R.	Capt	18 Nov 47
BELANGER, Renaldo G.	Major	3 Sep 47	SCROGGS, Howard R.	Capt	20 Nov 47
ADAMS, James J.	Major	1 Dec 47	COLYER, Andrew J.	Capt	7 Dec 47
MURPHY, George E.	Major	17 Dec 47	ALBRECHT, Lawrence S.	Capt	7 Dec 47
EGGER, Floyd C.	Capt	22 Sep 42	LARSON, Harold P.	Capt	7 Dec 47
YATES, Virgil T.	Capt	17 Nov 42	BRYAN, Roy A.	Capt	7 Dec 47
TARO, Alfred L.	Capt	22 Dec 42	COWGILL, Charles J.	Capt	7 Dec 47
FORTUNATO, Frank	Capt	8 Apr 43	PYTLEWICZ, Marion J.	Capt	7 Dec 47
WILKIN, Wendell R.	Capt	13 Jun 43	AHR, Lee A.	Capt	7 Dec 47
HITCHINGS, Donald L.	Capt	27 Jun 43	STEWART, Thomas B.	Capt	7 Dec 47
MONTAGUE, Ernest K.	Capt	29 Aug 43	RIDDLE, Hasty W.	Capt	7 Dec 47
FLINTJER, John D.	Capt	28 Feb 44	MARKS, Edward	Capt	7 Dec 47
GROVE, Lee A.	Capt	7 Jul 44	DOWLESS, Joseph D., Jr.	Capt	7 Dec 47
MC ALPINE, Arthur R.	Capt	9 Jul 44	GORRELL, Charles J.	Capt	24 Dec 47
FREEMAN, Richard R.	Capt	15 Jul 44	EDWARDS, Sam A.	Capt	24 Dec 47
MOLYNEAUX, Harold G.	Capt	21 Nov 44	WOLF, Charles R., Jr.	Capt	24 Dec 47
MOORE, Earl L.	Capt	14 Dec 44	DE SAUTELS, Francis O.	Capt	24 Dec 47
VIRE, Howard F.	Capt	27 Mar 45	SOUTHARD, William W., Jr.	Capt	24 Dec 47
LEE, William H.	Capt	27 Apr 45	LENN, Claude R.	Capt	26 Dec 47

X. Coliform Organisms in Milk - Published in HEALTH BULLETIN, Second Army, September 1949

Confusion among veterinary officers in interpreting laboratory reports of milk samples is apparently caused by two types of results:

1. Those in which the presumptive test in brilliant green lactose bile broth (1 cc of milk inoculated into each 5 tubes) shows coliform organisms (3/5, 4/5 or 5/5) and yet no coliform organisms are encountered on the plate count (1 cc plated with desoxycholate agar).

2. The wide variation in colon count reported on different samples showing the same results with the tube test (5/5).

It must be pointed out that the tube test is more sensitive than the plate test and thus will detect smaller numbers of organisms which the plate count may not reveal.

The colon index (tube test) is less subject to variations due to technical error than the plate count. All materials are used at room temperature, while in the plate method the medium is heated to boiling to melt the agar and then cooled to 45°C before using. If the medium should happen to be used too hot, bacterial numbers will be reduced.

In the tube test, 5 organisms per cc inoculum will give as definite a positive test as 50 organisms per cc. However, when these inocula are put into plates, the first should show only 5 colonies, and the latter ten times as many.

By the inoculation of a series of 5 tubes, it is possible to obtain a more accurate indication of the colon density than by the use of a single plate. This density is indicated by the MPN (most probable number) which is based upon a mathematical formula which has been found to be more accurate than a straight mathematical average. A reading of $3/5$ means an MPN of 92 organisms per 100 cc or .92 organisms per 1 cc and one of $4/5$ signifies 160 organisms per 100 cc or 1.6 organisms per 1 cc. When there is gas in all tubes, there must have been at least one organism per cc, with no possible means of defining the maximum number which might have been present.

Thus it can be seen that it is possible to have positive tubes and negative plates. With small numbers of organisms per cc, these apparent discrepancies are much more numerous than with those products containing larger numbers of bacteria. A finding of one organism or any greater number on the plate is consistent with fermentation in all five tubes.

It is inherent in this type of work that such variations occur. Results are relative, not absolute, and the same factors are at work with all samples. These analyses, though relative, are of great value in control work.

XI. Recent Department of the Army and FEC Publications



AR 600-45, 13 Oct 49, C-15 - Decorations: Bronze Star Medal, supersedes par 15 l e, Combat Medical Badge

AR 345-105, 17 Oct 49, C-1 - Records and Reports: Command and Unit Historical Reports

AR 10-342, 17 Oct 49 - Charter of the Armed Services Medical Procurement Agency. Supersedes Sec. IV, JAAF Bul 2, 1949. (The Armed Services Medical Procurement Agency is located at 84 Sands Street, Brooklyn 1, New York.)

AR 700-240, 17 Oct 49 - Supplies and Equipment - General: Materials Handling Equipment. Supersedes AR 850-16, 21 May 46, and Sec. II, DA Cir 25, 1947

DA CIR 112, 24 Oct 49 - Penicillin Crystalline, In Oil and Wax, 10 cc (Medical Stock No. 1-606-795). Dating Period Extended. (ED's NOTE: See Sec XII, par F, this issue S.C.L.)

SR 420-425-1, 19 Jul 49 - Repairs & Utilities. Water and Sewerage. Par 8. Swimming Pools. Par 9. Chlorination of Water. Par 13. Bacteriological Examination of Water

SR 40-590-15, 29 Aug 49 - Medical Service: Quarterly Report of Hospital Costs

SR 40-1005-1, 2 Sep 49 - Medical Service. Essential Technical Medical Data Report. Supersedes Memo. 40-1005-1, 18 Dec 46 and C-1; and Reports Control Symbol MED-35

SR 40-590-45, 30 Sep 49, C-1 - Par 3 b and 8 b Changed. Supersedes par 2 a (2)(a), AR 40-1715, 8 Nov 46

SR 350-20-1, 11 Oct 49 - Training of Military Personnel at Civilian Institutions. Applications, Waivers, Certificates

SR 32-160-40, 13 Oct 49 - Clothing and Equipage. Orthopedic Adjustments to Shoes. Supersedes Sec. II, AR 30-3045, 24 Feb 47

SR 40-530-10, 17 Oct 49 - Medical Service: Hospitalization in Medical Facilities in ZI of Non-Military personnel enroute to or from overseas. Par 3 b, DAC's; Par 3 c, Dependents; Par 4, Evacuation; Par 9, Civilian Seamen; Par 10, Pay Patients

SR 345-105-1, 17 Oct 49, C-1 - Records and Reports: Preparation of Command and Unit Historical Reports. Pars 6 b and 9 d Changed

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SR 140-15-1, 18 Oct 49 - ORC: Boards of Officers. Par 3 b, Physical Examination

SR 725-10-3, 18 Oct 49 - Issue of Supplies and Equipment: Submission of Requisitions to Army Depots

SR 600-440-1, 27 Oct 49, C-1 - Disposition of Psychotic: Addresses of Non-Federal Authorities Regarding Hospitalization of Psychotic Patients

DA FM 100-5, Aug 49 - Field Service Regulations - Operations Chap. 2, Sec VIII Medical Department Units

DA FM 7-30, Sep 49 - Service and Medical Companies Infantry Regiment

DA FM 100-10, Sep 49 - Field Service Regulations - Administration. Chap. 3, Staff. Par 43, Medical. Chap. 5, Logistics; Evacuation and Hospitalization. Chap. 6, Logistics; Sec II. Water

DA PAMPHLET 20-21, Jul 49 - The Army School Catalog: Medical Department, Pages 153 - 199 Inclusive. Officer and Enlisted Men Courses. Rescinds DA Pamphlet 20-21, 5 Mar 48 and SR 615-215-2, 9 Mar 49

T/O&E 8-640, 16 Sep 49 - Medical Field Laboratory, Army

T/A 20-4, 14 Jul 49 - Equipment for Posts, Camps and Stations Outside Continental United States

T/M 8-501, Sep 49 - Nutrition. Supersedes TB MED 23, 23 Mar 49; TB MED 25, 28 Mar 44

GHQ FEC CIR 54, 20 Oct 49 - Evacuation of Patients from and within the FEC. Rescinds FEC Cir 57, 23 May 47

PART II

TECHNICAL

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XII. Use of Outdated Materials Not Authorized



From time to time, misunderstandings become apparent concerning the significance of the expiration date on biologicals and other materials with assigned expiration periods. These materials lose their potency or ability to produce the desired effect at various rates. Manufacturers of these products are required by law to state on the container or package label the date beyond which the contents cannot be expected, beyond reasonable doubt, to yield their specific results. This date represents the termination of the potency period determined by long experience and defined by the responsible Federal agency for each type of product. Each product bearing an expiration date should be inspected carefully prior to issue or use to verify definitely that it is not outdated.

At the present time, the only materials authorized for use beyond the stated expiration dates are those listed below. All other dated materials which have reached their expiration dates should be disposed of as unserviceable material under existing regulations (Para. 111c, Technical Manual 14-904).

A. Albumin, Serum, Human, 25 Gm., 100 cc (Medical Item 1-582-010)

1. The dating period for Albumin, Serum, Human, 25 Gm., 100 cc (Medical Item 1-582-010) has been established by the National Institute of Health to be 5 years from the date of manufacture. This represents an extension of 2 years over the period formerly set. Accordingly, authority is given to use albumin, serum, human, now in stock with expiration dates in 1946 or 1947 for 2 years after stated expiration date, provided that there is no cloudiness or precipitate present.

2. Albumin, serum, human, bearing expiration dates later than 1947, will not be used beyond

the dates shown, since such dates will represent the maximum permissible expiration period.

Reference: Department of Army Circular #195, 1 July 1948

B. Plasma, normal human, dried, Item No. 1-607-100 and plasma, normal human, dried, 500 cc, Item No. 1-607-104: Pending receipt of new or reprocessed stock Nos. 1-607-100 plasma, normal human, dried, 250 cc, and 1-607-104, plasma, normal human, dried, 500 cc, installation medical personnel are authorized to use stocks on hand, even though the expiration date on the label or package has passed, provided the rubber stopper and tubing are in good condition and mixture with solution is satisfactorily effected.

Reference: Department of Army Circular #88, AFL #160-26, 24 June 1949

C. Fibrin Foam and Thrombin, Human (Medical Item 1-604-785):

1. The dating period for Fibrin Foam and Thrombin, Human (Medical Item 1-604-785) has been established by the National Institute of Health to be 3 years from the date of manufacture. This represents an extension of 1 year over the period formerly set. Accordingly, authority is given to use Fibrin Foam and Thrombin, Human, now in stock with expiration dates in 1947 and 1948, for 1 year after the stated expiration date.

2. Fibrin Foam and Thrombin, Human, bearing expiration dates later than 1948 will not be used beyond the dates shown, since such dates will represent the maximum permissible expiration period.

Reference: Department of Army Circular #273, 9 September 1948

D. Streptomycin, 1 Gm (Medical Item 1-609-840): The dating period for Medical Item 1-609-840, Streptomycin, 1 Gm, has been extended for a period not to exceed 3 months from date of expiration as stated on the package, provided the item has been stored under proper conditions at approximately 22° Centigrade (approximately 70° to 75° F.).

Reference: Department of Army Circular #361, 19 November 1948

E. Penicillin Crystalline, Oil and Wax, Medical Stock No. 1-606-795, 10 cc, Lot No. 47081831-R: The dating period for Medical Stock No. 1-606-795, Penicillin Crystalline, Oil and Wax, 10 cc, Lot No. 47081831-R, manufactured by Commercial Solvents Corporation, is extended to 1 June 1950. Accordingly, stocks of this lot number should be used until that date, in spite of the expiration date shown on the package as February 1949.

Reference: Department of Army Circular #93, 4 August 1949

F. Penicillin Crystalline, In Oil and Wax, 10 cc (Medical Stock No. 1-606-795): The dating period for Medical Stock No. 1-606-795, Penicillin Crystalline, in Oil and Wax, 10 cc, for the following lot numbers, manufactured by C.S.C. Pharmaceuticals (Division of Commercial Solvents Corporation), is hereby extended to 31 August 1950:

47093031-R	47100931-R	47101331-R
47100731-R	47101831-R	47100231-R
47101031-R	47102031-R	47100831-R
47100431-R	47100631-R	47101131-R

Accordingly, stocks of the above lot numbers should be used until that date, despite the expiration date shown on the package as April 1949.

Reference: Department of Army Circular #112, AFL #160-195, 24 October 1949

XIII Influenza



True epidemic influenza was last demonstrated in the Far East Command in the early months of 1947 when a sharp rise in respiratory infections was found to be due, in part at least, to influenza A. Since then there has been no unusual prevalence of respiratory disease. During the past season (1948-1949), the highest reported incidence of common respiratory disease and influenza was 120/1000/per annum reported in March; this representing an increase of 30 from the previous

month. Since April this year, the rate has been consistently below 50 until October when an incidence of 60 per 1000 per annum was reported.

It has been postulated that influenza A and B recur in separate cycles in the United States; the former at two to three years interval and the latter every four to six years. If these cycles are applicable to the Far East or to Americans in the Far East, the occurrence of one or the other of these infections here this year is a possibility to be borne in mind. The presence of epidemic influenza should be seriously considered if there occurs a significant rise in the incidence of respiratory infections with symptoms and signs consistent with those commonly associated with influenza.

In this connection, it is emphasized that in non-epidemic periods and in the early phases of an outbreak, the clinical diagnosis of influenza cannot be supported without substantiating laboratory evidence. This evidence is obtained through specific laboratory procedures. The 406th Medical General Laboratory in Tokyo is equipped to perform the necessary tests. Medical officers are urged to submit serum specimens as outlined below in cases of suspected influenza. It is particularly important that these specimens be submitted during the early phases of an outbreak in order that the true nature and type of infection present may be established.

An acute phase blood serum specimen (8 to 10 cc) should be obtained aseptically within 48 hours of the onset of illness in suspected influenza cases. This specimen should be forwarded to the 406th Medical General Laboratory immediately by the most expeditious route, followed by a second or convalescent specimen obtained 7 to 10 days later. Each specimen should be accompanied by appropriate laboratory slips presenting the patient's name, rank, serial number, organization, name of submitting institution, suspected diagnosis, date of onset of illness, and the date of collection of the specimen. The hemagglutination-inhibition antibody titers of these serum specimens will be determined. The usually accepted diagnostic finding is a four-fold or greater increase in antibody level of the convalescent specimen over that found in the acute specimen. This comparison of the two antibody levels is essential; hence, a single serum specimen is of no value and the test is made only after receipt of the second or convalescent serum specimen.

Suspected or proven outbreaks of influenza should be reported immediately to the Chief Surgeon, Far East Command. Reports Control Symbol MED-16 applies.

XIV. Vagotomy Versus Subtotal Gastric Resection in the Surgical Treatment of Duodenal Ulcer - Lt. Col. Sanford W. French, III, MC, 118th Station Hospital, APO 24-5



Since Dragstedt first performed bilateral vagotomy on a human subject in January 1943 (1), interest in this method of therapy has become widespread and thousands of vagotomies have been done all over the world. The results of these operations, however, as reported by various writers have been equivocal. This requires explanation.

It will be noted that most of the unfavorable reports concerning vagotomy come from writers reporting on small series of cases, whereas the favorable reports usually come from the larger series. As an example of the latter, Crile and co-workers (2) treated 87 consecutive cases of refractory duodenal ulcer by subtotal gastrectomy and then treated the same number of consecutive cases by vagotomy and a drainage operation on the stomach (gastro-enterostomy or pyloroplasty) and concluded that vagotomy and a drainage operation on the stomach gave better post-operative results than subtotal gastrectomy. At this point, another question immediately arises - what is going to happen to these vagotomized patients in twenty or thirty years? Time only will give us the answer to this question. Dragstedt's first case is now 6½ years post-operative and no ill effects have been noted.

As the pendulum has now swung to vagotomy and a drainage operation, usually gastroenterostomy, instead of vagotomy alone, most vagotomies are now done through the abdominal approach. Transabdominal vagotomy is technically a more difficult procedure than transthoracic vagotomy, due to the anatomy of the vagus nerves at the lower end of the esophagus. After cutting the two vagi at the lower end of the esophagus, a most careful search must be made for anomalies of the nerves or any little twigs which might have been missed. Through the chest, the vagi stand out as two prominent cords, but this approach is not as favorable for gastro-enterostomy.

In essence, then, abdominal vagotomy is a technically difficult procedure, and the operator with little or no experience in this operation is very likely to perform an incomplete vagotomy with subsequent poor post-operative results. Herein lies one of the reasons for the poor results obtained

in the smaller series various writers have reported on. All 87 cases reported by Crile were done by two surgeons, and it is to be noted that their results became better as the series progressed.

Another reason for the poor results with vagotomy described in some of the early papers on the subject is that vagotomy alone was done. Personal experience with vagotomy alone has shown that many of these patients will return to the hospital with symptoms of partial or complete obstruction, either because of cicatricial contraction due to healing at the ulcer site or due to the severe pylorospasm which sometimes follows vagotomy. These patients have required gastro-enterostomy at a second operation. The results, however, on patients having a one stage complete vagotomy and gastroenterostomy have been uniformly good in my experience with fifty cases (3). Indeed, it might be said that gastroenterostomy (which will heal 85% of ulcers, but had to be abandoned as a single procedure because of the 15% of cases who later developed marginal ulcer) is the main operation with vagotomy being performed merely to prevent the occurrence later of a marginal ulcer.

Subtotal gastric resection is the time honored and tested method of treatment of refractory duodenal ulceration. This operation has been performed over a sufficient number of years to prove its general worth, and probably this is one reason why the older group of surgeons are reluctant to change over to a new operation, the full evaluation of which cannot be expected for another twenty years.

Griswold (4) has recently brought attention to an entirely new concept which he suggests might possibly be used in the preoperative evaluation of the postoperative effects of both vagotomy (and gastroenterostomy) and subtotal gastric resection in any given patient being considered for surgery. He calls attention to the two chief mechanisms for the stimulation of gastric secretion, (a) the humoral phase, which is initiated by the presence of food in the pyloric end of the stomach or intestine and (b) the vagal or cephalic phase, which is initiated by smell or taste of food, thought, or emotional psychic phenomena. Histamine stimulates humoral secretion. Hypoglycemia produced by insulin stimulates vagal secretion. In brief, the choice of operation lies in the predominance of either one of the two phases of secretion, humoral or vagal. If a patient shows a poor response to histamine but a good response to hypoglycemia, vagotomy would seem to be the operation of choice. If the humoral response is dominant, subtotal gastric resection is indicated. Actual experience with preoperative evaluation of patients by this method and the postoperative results obtained, will probably be forthcoming.

While certain aspects of the technique of abdominal vagotomy are more difficult than subtotal gastric resection, it is a less shocking operation than the latter and requires less time to perform. In addition, none of the stomach is removed; consequently, many small feedings, such as is required in an individual who has had 75 to 80% of his stomach removed, is not a factor. The "dumping" syndrome is less frequent in occurrence following the gastroenterostomy done with vagotomy than that done with gastric resection. If a vagotomy is a frank failure, resection may always be resorted to at a later date. If initial adequate resection is a failure, the end of the road is near at hand insofar as any more surgery is concerned.

SUMMARY:

1. Reports from various sources on the efficacy of vagotomy in the surgical treatment of refractory peptic ulceration are equivocal. A possible explanation is offered.
2. Favorable results from this operation usually come from writers reporting on a large series of cases.
3. A new method for the preoperative evaluation to determine what type of operation, vagotomy with gastroenterostomy or subtotal gastric resection, would be most beneficial for any given patient, as outlined by Griswold, is discussed.

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- (1) Dragstedt, L. R., and Owens, F. M., Proc Soc Exper Biol and Med, 53: 152-154, 1943.
- (2) Crile, G., Jr., Jones, T. E., Davis, G. B., Annals of Surgery, 130: 31-37, 1949.
- (3) Bergman, P. A., French, S. W., and Seeley, S. F., Mil Surg, 104: 331-336, 1949.

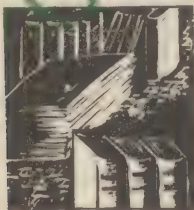
XV. Danger of Local Use of Penicillin and Sulfonamides in Treatment of Skin Disorders

It is now well established that the local use of penicillin and sulfonamides on the skin produces a high incidence of sensitization reactions¹. The skin perhaps becomes sensitized more readily than any other tissue in the body. If sulfonamides are used for the pyoderms, it is strongly recommended that they be given orally, and if penicillin is indicated, it should be given parenterally.

R. E. B.

¹Clarence S. Livingood, Medicine of the Year 1949, J. B. Lippincott & Co.

XVI. Intravenous Alimentation and Preoperative Preparation - Captain R. J. Burkhard, MC, presented at a Surgical Conference, Tokyo General Hospital, Tokyo, Japan. (Part II of Two Parts)



The surgical patient should be weighed daily and at the same time every day. Increased or steadily maintained body weight is the best sign of success of any intravenous alimentary regime.

24 HOUR FLUID BALANCE

Last Name, First Name, Middle Initial						Diagnosis:						
Weight (lbs) 0700 Hrs.						From 0700 Hrs. To 0700 Hrs.						
I N T A K E												
ORAL INTAKE		PARENTERAL INTAKE		TOTAL FLUIDS	PROTEIN GRAMS	CBH GMS	CAL-ORIES	NITRO-GEN	SALT GMS			
Type	Amt.	Type	Amt.									
TOTAL:		TOTAL:										
DAILY REQUIREMENTS				3500	70-150	200-350	1200-2000	10	6			
O U T P U T												
URINE		VOMITUS		GASTRIC DRAINAGE		FISTULA DRAINAGE	LIQUID STOOL	TOTAL FLD. LOSS	VITAL SIGNS			
Time	Amt.	Time	Amt.	Time	Amt.				Time	B.P.	P.R.	R.R.
Ttl												
Norm.	1500	Ttl.		Ttl.		Ttl.	Ttl.					

TYPE OF FLUID	GMS CBH	GMS PROTEIN	CALOR-IES	SALT GMS	NITRO-GEN GMS	1% SODA BICARB
1000 c.c. 5% Glucose in N/S	50		200	9		
1000 c.c. 5% Glucose in D/W	50		200			
1000 c.c. 10% Glucose in N/W	100		400	9		
1000 c.c. 10% Glucose in D/W	100		400			
1000 c.c. N/S				9		
1000 c.c. 1/8 Molar Lactate						1000
1000 c.c. Protein Hydrolysate (Baxter)	50	50	400		6	
1000 c.c. Amigen 5%	50	50	400	2	6	

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TYPE OF FLUID	GMS CBH	GMS PROTEIN	CALOR- IES	SALT GMS	NITRO- GEN GMS	1% SODA BICARB
1000 c.c. Parenamine 6%	50	60	440		20.5	
1000 c.c. Amigen 10%	50	100	600	2	12	
1000 c.c. Plasma					12	

Allen's Formula for Hyperglycemia:

$$\text{Units of Insulin} = \frac{303 \times \text{wt. in lbs.} \times .00000 \text{ Dif. in Pt.s \& Normal Blood sugar}}{2}$$

1/6 Molar Lactate Formula for Acidosis:

$$\text{cc of Molar Lactate} = (60 - \text{Pt's CO}_2) \times (0.3 \times \text{wt. in kilo's})$$

Ammonium Chloride Formula for Acidosis:

To lower CO₂ value 1 vols. %, give 50 c.c. 2% ammonium chloride

Sodium Chloride Formula:

For each 100 mgms %. To reach normal level give 0.25 gms. salt/kilo.

Acetonuria Rule:

If acetone in urine increase amount of glucose.

NPN Rule:

To maintain normal NPN keep 24 hour urinary volume at 1500 c.c.

Water & Electrolyte balance are adequate if 24 hour urinary output is 1500 c.c. and 24 hour urinary salt is 36 ms.

If patient is clinically severely dehydrated, 6% of body weight has been lost and 4000 c.c. of fluid should be added to daily requirements for first day.

Corrected Wangensteen drainage contains 56 ms of salt/1000 c.c. (Total volume of drainage - invested water)

Sweat contains 36 ms of salt/1000 c.c.

To each non-protein intravenous bottle, add 300 mgm ascorbic acid, 10 mgm. thiamine, 50 mgm. nicotinic acid, 5 mgms. calcium pantothenate, 2.4 mgm alpha menadione.

Reactions due to intravenous protein administration do occur in approximately 4% of the patients. Reactions are ushered in by a sudden onset of fever, with or without chills, nausea, vomiting and abdominal pain. If a reaction does occur it is well to observe the patient very closely throughout the entire regime of intravenous alimentation for phlebothrombosis as there is an increased incidence in this group. If reactions are encountered, it is advisable to change to a new bottle of intravenous proteins or to another commercial brand of protein and to slow the rate of administration so that not more than 15 gms of protein are given per hour.

All intravenous fluids should be inspected prior to usage for contamination which is usually manifested by a turbidity or flaking precipitate in the fluid.

Intravenous alimentation is contraindicated in:

1. Hemorrhagic shock (blood NPN rises rapidly and intravenous alimentation may also lead to a serious hemodilution).
2. Extensive liver damage (no deamination takes place in a seriously impaired liver).
3. Heart failure (fluids may lead to an increased burden on a previously taxed heart and to more decompensation).
4. Renal insufficiency (the kidney is unable to excrete metabolic products and a piling-up results).

Daily laboratory studies on the blood and urine should be ordered until all laboratory work can be maintained in a normal range. The most important blood studies in our consideration are BUN, CO₂, Chlorides, Sugar, Total proteins, Albumin-Globulin ration. The urine studies are, Specific Gravity,

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24 hr. volume, reaction, sugar, albumin, acetone, quantitative salt and microscopic analysis.

Below are listed some pertinent formulae that assist in regulating erratic blood chemistries.

1) **ALLEN'S FORMULA FOR HYPERGLYCEMIA:**

$$\frac{303 \times \text{Wt. in lbs} \times .00000}{2} (\text{difference in patient's and normal blood sugar}) = \text{units of insulin required}$$

2

E.G. A patient with a blood sugar of 200 mgms % - Wt. 150 lbs.

$$\frac{303 \times 150 \times .001.00}{2} (200-100) = 22 \text{ units of insulin required}$$

2) **1/6 Molar Lactate Rule for acidosis:**

cc of 1/6 M Lactate = $(60 - \text{pt's CO}_2) \times (0.3 \times \text{wt. in kilos})$

E.G. A patient with a CO₂ of 40 - Pt's wt. is 70 kilos.

$420 \text{ c.c. } 1/6 \text{ M Lactate} = (60-40) \times (0.3 \times 70)$

3) **AMMONIUM CHLORIDE FORMULA FOR ALKALOSIS:**

To lower CO₂ value 1 vol% give 50 c.c. 2% ammonium chloride (1 gm)

4) **SALT RULE:**

For each 100 mgms% to reach normal level (500-600) give 0.25 gms of salt/kilo.

5) **ACETONURIA:**

If acetone appears in the urine, increase the amount of glucose given. (Ketosis may be detected by acetonuria, acetone odor to breath, nausea, anorexia, acute abdominal pain (due to acidotic smooth muscle spasm) and general signs of dehydration).

It is important to note at this point that a latent diabetes may be stirred to activity by a surgical operation or by a postoperative ketosis.

6) The NPN may be sustained within normal limits by keeping the urinary 24 hour volume above 1500 c.c. Of importance is the fact that the NPN does not rise until renal function is reduced 30%.

Postoperative intravenous alimentation may be terminated when the patient begins to take nourishment by mouth and when he is able to utilize orally ingested food. For the average patient this can be forecast by auscultating the abdomen for the appearance of peristaltic sounds and by noting passage of flatus rectally.

The patient should be given a trial of oral alimentation prior to discontinuing the intravenous regime. If a Wangenstein tube is being used, the patient is placed on several ounces of water by mouth with the Wangenstein clamped for 1/2 hour after the water is given. Water may be offered every hour if it is tolerated. If the patient retains water for 12-24 hours, the Wangenstein suction may be discontinued. A surgical liquid diet may then be given. It is well to remember that the intravenous fluids may be decreased by the amount of fluid that is orally ingested. All intravenous fluids are usually discontinued on the 2nd day of a tolerated surgical liquid diet.

FLUID BALANCE IN SPECIAL CONDITIONS:

BURNS

For assistance in correcting shock, anemia, hypoproteinemia, and altered metabolism as well as forestalling a lower nephron nephrosis, the following regime is offered.

FLUID REQUIREMENTS:

1) Wound edema (if burned area is over 20% of the total body area) 10% of body weight in grams.

E.G. 70 kilo male - $70,000 \times 0.1 = 7000 \text{ c.c.}$

2) External loss - If burned area from 25-35% total body area -- 1000 c.c.

If burned area from 35-60% total body area -- 2000 c.c.

If burned area from 60%-? total body area -- 3000 c.c.

Add 1) and 2) E.G. 40% burns on 70 kilo patient.

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1) 7000 plus 2) = 9000 c.c. of fluid required.

Give 2/3 as blood. (Plasma is acceptable only if blood is not available).

Give 1/3 as 1/6 molar lactate or glucose in saline.

Of the entire volume of 9000 c.c., 1/2 (4500 c.c.) is given in first 12 hours. (E.G. 3000 c.c. blood and 1500 c.c. 1/6 molar lactate). 1/4 (2250) is given in second 12 hours. (E.G. 1500 c.c. blood and 750 c.c. given as glucose in N/S); 1/4 (2250) is given in following 24 hours. (E.G. 1500 c.c. blood and 750 c.c. given as glucose in N/S)

3) 1500 c.c./24 hours to be given to cover renal loss; 1/2 (750) as 5% glucose in N/S; 1/2 (750) as 5% glucose in D/W.

4) 1500 c.c./24 hours to be given to cover insensible loss: 1500 c.c. 5% glucose in D/W.

As a resume:

During the first 24 hours are given 6750 c.c. (Wound edema & ext. loss)
 1500 c.c. (Renal loss)
 1500 c.c. (Insensible loss)
 9750 c.c.

During the second 24 hours are given 2250 c.c. (Wound edema & ext. loss)
 1500 c.c. (Renal loss)
 1500 c.c. (Insensible loss)

After 48 hours, the hemoglobin and hematocrit should be in normal range, and a normal intravenous alimentation regime may be instituted. The urinary output should remain normal throughout the period of therapy (1500 c.c./day) and should be withdrawn via a retention catheter.

Choline (1 gm tid) or methionine (0.5 gm tid) is to be given every day to prevent depletion of protein stores as the tissue proteins are raided for methionine following burns.

OBSTRUCTION

Fluid balance in obstruction is a little more complicated than routine intravenous alimentation. It is important to note that the greatest fluid loss is not from vomiting but from pooling of fluids in the obstructed bowel. For this reason, the lower the obstruction, the more fluid that can be pooled and therefore the more serious the disturbance in fluid balance and hence mortality.

As an example of the amount of fluid that can be lost in a low obstruction, the following figures are well to analyze. These represent minimal and maximal amounts of fluid/24 hours that is secreted and excreted into the intestinal canal.

		MINIMAL	MAXIMAL
IF VOMITING	SALIVARY GLANDS	500	1500
ACID LOSS	STOMACH	1000	2400
	INTESTINAL WALL	700	3000
ACID LOSS	PANCREAS	700	1000
BASE LOSS	LIVER (BILE)	100	400
	LYMPH	700	1000
		3700	9300

From the above figures it can be seen that massive fluid loss can occur by pooling of intestinal fluids into an obstructed bowel. Fortunately, however, in early obstruction the bowel retains its capacity in a diminished manner to absorb some of these fluids, thus reducing the early possible serious consequences of fluid and electrolyte loss. Most patients are diagnosed early and corrective surgery can be performed before fatal fluid loss occurs.

The acidity or alkalinity of fluid loss in various portions of the intestinal canal can be appreciated with the diagram.

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In upper bowel obstruction the early important changes are as follows: 1. Chlorides are vomited leading to a decrease in the CO₂ combining power. 2. Fluid loss by vomiting may be accepted and lead to concentration of the plasma. Intracellular fluid replenishes this loss from the blood stream and leads to a dehydration, oliguria, and a rise in the blood NPN.

Blood potassium increase is rare in an intestinal obstruction and if it does occur, may lead to an increase capillary permeability. The proper treatment for a high blood potassium level is the administration of adrenal cortical extract.

HEPATIC PATHOLOGY

All intravenous fluids containing proteins and carbohydrates should be given at 1/2 the normal rate as the utilization of carbohydrates and proteins are reduced as much as 50% in the face of moderate liver pathology. The amenization is depressed relatively early in liver pathology and excessive intravenous proteins leads to frequent reactions.

LOWER NEPHRON NEPHROSIS

Lower nephron nephrosis which occurs on or about the 3rd postoperative day is best treated by restriction of fluids to 1500 c.c. per day and 100% curtailment of salt intake. As soon as the urinary output increases the patient may be placed on routine 24 hour alimentation.

HEMORRHAGE

Hemorrhage is best treated by whole blood transfusions; 50 cc for every percent that the hemoglobin falls below normal value; a hundred cc for every point reduction in hematocrit. As soon as shock is controlled and the red blood count, hemoglobin and hematocrit are within normal range and the patient stabilized the routine 24 hour alimentation may be used if necessary.

Preoperative preparation is a most important phase of the parenteral surgical management of a patient. For major procedures a preoperative complete blood count, bleeding time and clotting time, and urinalysis is requested in addition to the following blood chemistries: NPN, CO₂, blood chlorides, blood sugar, total protein, and AG ratio. All chemistries must be in the normal range, before surgery is attempted. It takes 24 hours to correct minor aberrations. In cases of emergency adequate control can be obtained in 2 to 6 hours. It is very important to weigh an emergency carefully as to the amount of time that can be safely spared in order to prepare the patient. It goes without saying that dire emergencies are operated immediately with indicated fluids given on the table. One is never to operate a patient in shock without controlling the shock first.

In addition to the chemistries already mentioned the patient should be weighed preoperatively in order to obtain a baseline for the nutritional evaluation, in the postoperative stage. The patient is requested also to void immediately prior to the operation and if this cannot be done the patient is catheterized.

For minor procedures a CBC, bleeding time and clotting time and urinalysis usually suffice unless other laboratory work is specifically indicated.

Before all surgical procedures it is advisable to place the patient on one week's therapy of ascorbic acid, 200 mgm, 3 times a day, and in addition the patient should receive 2 mgm of vitamin K, the night before surgery.

PREOPERATIVE AND POSTOPERATIVE CARE OF CHILDREN

Children pose new problems for preoperative and postoperative care as they are more prone to pediatric complications and because fluid balance and requirements are perhaps not as well known as in the adult, also because fluid balance occurs very rapidly in children.

Preoperative preparations as far as laboratory work and preoperative vitamin therapy are the same for the adult and child. Fever, incipient coryza, cough and reddened throat are absolute contraindications to operation with the exception of emergencies. Respiratory complications during anesthesia are more serious in the child than in the adult. If the child has been exposed to any exanthemata, surgery should be postponed until after the incubation period.

Following operation, the child should be placed in a warm room, free from drafts, and should be adequately sedated.

POSTOPERATIVE REQUIREMENTS FOR CHILDREN:

I. FLUIDS:

Infant.	.1500 cc/kilo)	This amount is to be added to the amount lost by perspiration, diarrhea, vomiting, etc.
6 yrs of age.	100 cc/kilo)	
14 yrs of age.	60 cc/kilo)	

The rate of administration is 1 cc/min Infant
 5 cc/min Older child

II. URINARY OUTPUT:

Infant.	.200-500 cc/24 hrs.
6 yrs of age.	.500-800 cc/24 hrs.

III. TREATMENT OF HEMORRHAGE OR SHOCK:

Infant.	.15 cc blood or plasma/kilo
-----------------	-----------------------------

IV. PROTEIN REQUIREMENTS:

Infant.	.4 gms/kilo	(Not less than 1 gm/kilo)
4 yrs of age.	.2.5 gms/kilo	(Not less than 1 gm/kilo)

V. CALORIC REQUIREMENTS:

Infant.	.110 calories/kilo
4 yrs of age.	.100 calories/kilo
7 yrs of age.	90 calories/kilo
10 yrs of age.	80 calories/kilo
13 yrs of age.	70 calories/kilo
16 yrs of age.	60 calories/kilo

VI. VITAMIN REQUIREMENTS:

Same as for the adult in general with the exception of vitamin D which is to be given daily 400-800 units.

The hospital stay should be terminated as soon as good surgical judgment will allow. This is done in order to lessen postoperative infections which are bound to occur in long hospital stays in a pediatric ward.

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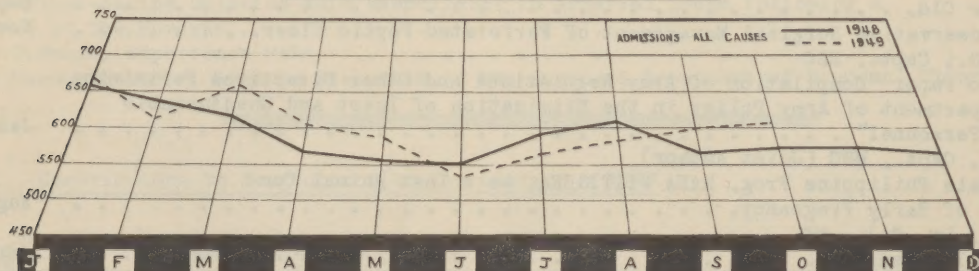
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PART III - STATISTICAL

HEALTH OF THE COMMAND



Admission rates per 1000 troops per annum for the four-week period ending 28 October 1949 were as follows:

	FEC	JAPAN	MARBO	PHILCOM	RYCOM
All Causes	609	660	262	449	557
Disease	557	604	220	403	520
Injury	53	57	42	46	38
Psychiatric	8.9	9.8	4.5	11	5.9
Common Respiratory Diseases & Flu	60	69	23	63	25
Primary Atypical Pneumonia	3.1	3.7	1.1	4.4	0

	FEC	JAPAN	MARBO	PHILCOM	RYCOM
Common Diarrhea	4.3	.99	0	2.2	27
Bacillary Dysentery	.42	.11	0	2.2	2.0
Amebic Dysentery	.33	0	0	4.4	1.3
Malaria, new	1.3	.77	0	0	5.9
Infectious Hepatitis	3.4	2.3	2.2	11	8.5
Mycotic Dermatoses	3.5	3.8	3.3	0	2.6
Rheumatic Fever	.42	.44	0	0	.65
Venereal Diseases	196	206	44	162	234

The admission of 7,350 patients to hospitals, dispensaries and quarters for all causes during the 4-week period ending 28 October 1949 gives a rate of 609 as compared to 599 for September. A gradual increase in the admission rate for all causes has been experienced since June of this year; however, the health of the command continues good and the increase in admissions for this month results from an increase in common respiratory disease incidence. The common respiratory disease incidence is perhaps below that normally expected for this season of the year.

The average daily non-effective rate for all causes during October was 18. This is considered very good and compares with the rate of 20 for the same period last year for this command, and 21.5 for total Army for the month of July of this year.

DISEASES: Common Respiratory Diseases and Influenza: The rate for common respiratory diseases and influenza increased from 42 per 1000 personnel per year for September to 60 for October. This rate is considered unusually low for the season and compares to a rate of 71 for this command for October 1948. The rate for October 1948 for the ZI and European Command was 61 and 84 respectively. While the moderate increase in the occurrence of respiratory infections is not indicative of the presence of flu, the possibility of the occurrence of this disease later in the season must be kept in mind. Page 7 in this Circular is a note referring to this possibility and to the methods to be employed for specific diagnosis should influenza be suspected.

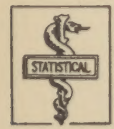
Malaria: Malaria incidence rate continues at a low level. The FEC rate for total malaria was 3.2. No cases were reported from MARBO or PHILCOM (AF). The rate of new malaria in Japan for the month of October was .77 and for RYCOM 5.9.

Diseases of the Central Nervous System: There were 16 cases of poliomyelitis reported among occupation personnel during October. All of these were in Japan. There were no new cases of Japanese B encephalitis during the month. A summary of the occurrence of polio and Japanese B encephalitis among occupation personnel during the year will be presented in a subsequent issue of the Circular.

During the month there occurred in PHILCOM (AF) a group of mild cases considered to be infections of the central nervous system. The findings in these cases were not compatible with any of the well recognized central nervous system infections and studies to date have not yielded an explanation of their etiology. No fatalities occurred; the patients all recovering within a few days after onset. A series of cases reported as possible non-paralytic polio from RYCOM during September are now considered to be encephalitis of unknown cause. These cases, in general, have been relatively mild. Clinical and laboratory studies in both of these situations are being continued.

Venereal Diseases: The rate of total venereal diseases for the command decreased from 206 in September to 196 in October. The decrease is attributable entirely to RYCOM and more specifically, the colored component thereof. In comparison with the previous month, the RYCOM colored rate for total venereal diseases decreased from 867 to 490 and the white from 227 to 187. The rate on total venereal diseases for that command decreased from 326 to 234.

Evacuation: Tabulated below are the number of patients evacuated from the major commands to the ZI during the 4-report weeks in Oct and the number of patients awaiting evacuation as of 28 Oct:



	JAPAN	MARBO	PHILCOM	RYCOM	FEC	TOTAL
BY AIR	59	22	22	3	106)	128
BY WATER	15	4	2	1	22)	
PNTS AWAIT EVAC	206	2	15	63	286	286

Evacuations of military personnel per 1000 strength for the period of 1 Oct to 28 Oct were as follows:

JAPAN .50; MARBO 1.9; PHILCOM 4.0; RYCOM .20; FEC .70

Hospitalization: The bed status as of 28 Oct 49 was as follows:

	Total T/O Beds Auth.	Total T/O Beds Establ.	Total T/O Beds Occupd.	% Auth. T/O Beds Occupd.	% of Establ. Beds Occupd.
JAPAN	4,600	4,176	1,965	43	47
MARBO	125	125	75	60	60
PHILCOM	1,000	1,000	576	58	58
RYCOM	750	443	244	33	55
FEC	6,475	5,744	2,860	44	50

Arnold



The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor